We Are Still Here.
We Are Still Vital.

We Are Learning Disability Nurses.

A Report from the Kent and Medway RNLD CPD Event 17 February 2026

April 2026

To Every RNLD, and Ally Who Was There, and Those Who Couldn't Be

On 17 February 2026, more than thirty-five professionals from across Kent and Medway gathered for a day focused entirely on learning disability nursing. They came from everywhere this specialism reaches: community teams, acute hospitals, mental health services, forensic care, CAMHS, universities, social care, and lived experience organisations. One was retiring after forty years in the NHS. One was a student nurse, just beginning.

Three structured activities asked everyone in the room to do something that happens too rarely in healthcare: to speak honestly about who they are, what their work actually does, and what they believe needs to change.

This report is a record of what was said. But it is also something else: it is evidence. Evidence that can be placed in front of commissioners, Chief Nurses, and workforce planners. Evidence that the people who do this work have gathered, in their own words, together.

Wherever you are in your LD nursing journey, whether a student, specialist, manager, retiree, or ally, this document belongs to you. Read it. Share it. Use it. A companion report has also been developed for Chief Nurses and system nursing leaders, which can be shared on request.

With respect and solidarity,

The Kent and Medway RNLD CPD Event Organising Group

What We Are Going to Do

Before the details, here is what this report proposes. These three collective actions are grounded directly in what participants said across all three activities. The evidence behind each one is set out in the chapters that follow.

> **COLLECTIVE ACTION 1:** Establish a formal Kent and Medway LD Nursing Network, meeting at least quarterly, with lived experience representation and a shared agenda linked to local workforce planning. You told us the CPD event was exactly the kind of space you need more of, ***so we build on it***.

> **COLLECTIVE ACTION 2:** Develop and launch a coordinated outreach programme into at least five schools or colleges across Kent and Medway within twelve months, co-delivered by LD nurses and lived experience partners. You told us LD nursing is invisible to young people, ***so we make it visible***.

> **COLLECTIVE ACTION 3:** Agree on a small working group to develop a data and outcome framework that captures the preventative impact of LD nursing. You told us the qualitative case is strong, but the quantitative case needs work, ***so we start building it***.

The rest of this report sets out where these actions came from and why they matter. If you only have five minutes, read this page and the final chapter. If you have more, the evidence in between is worth your time.

Chapter 1

Who Are We?

Activity 1: Taking Stock of Our Collective

The first activity asked everyone in the room to introduce themselves, where they work, what they do, how long they've been in this field, and what they most value about their work. The numbers below give a sense of the scale of what was in that room. The words that follow are harder to summarise, because what people wrote about why they do this work did not read like a form; it read like a vocation.

The Room at a Glance

35	500+	15+
Participants	Combined Years Experience	Organisations Represented

The group included community LD nurses, mental health LD nurses, specialist pharmacists, a physiotherapist, commissioners, academics, a managing director, a case manager in secure forensic services, a lived experience team leader, a CAMHS specialist, a student nurse, and someone who qualified as an RNMH thirty-six years ago, left nursing, retrained as a podiatrist, and returned to LD nursing through a return-to-practice route.

That last detail matters. It is a small data point that contains a large truth: people come back to this work. Even when they leave, they come back. That is not true of many specialisms.

What We Said We Value

The question "What do you most value about your work?" generated responses that clustered around four themes. Rather than paraphrasing what was said, here is what it means for what we do next.

Advocacy — and why it matters systemically Advocacy was the most frequently named value. For Chief Nurses and commissioners reading the parallel version of this report, that word is evidence: it means LD nurses do something that the system otherwise does not, they ensure that people with learning disabilities are seen, heard, and responded to within services that were not designed with them in mind. For us, it is a reminder that advocacy is not peripheral to the role. It is the role.

Relationships Participants described their work in relational terms, the relationship with the person, the family, and the whole network over time. This is structurally different from how most of the NHS measures and values nursing contacts. It is also why LD nursing cannot be reduced to a number of appointments or a caseload figure.

System change Many participants described the opportunity to shift how organisations behave as what gets them out of bed. This systemic orientation, not just caring for individuals but changing how the system cares, is one of the most under-documented contributions LD nurses make. It is also the hardest to quantify, which is exactly why we need better data (see Collective Action 3).

The person One participant answered the question "What do you most value about your work?" with a single word: "Person." There is a quiet radicalism in that answer. In a system that increasingly measures activity, contacts, and throughput, the thing this community values most is the human being in front of them.

> **WORTH NOTING:** One participant is retiring after 40 years in the NHS. Another was a student nurse just starting out. Both were in the same room, contributing equally to the same conversation. That is what a living specialism looks like. It is exactly what we need to protect.

Chapter 2

What Our Work Actually Does

Activity 2: Making the Case

Activity 2 asked participants to articulate the difference LD nurses make, to individuals and families, to teams and systems, and what would be lost without these roles. The responses are organised below by theme. Rather than listing everything that was said, this chapter draws out the key arguments and what they mean for the case we need to make.

If you are building a business case, preparing a presentation for your Trust Board, or writing a funding bid, the evidence in this chapter is yours to use.

What We Do for People and Families

Participants described an approach to nursing that is qualitatively different from other specialisms. Three arguments appear with enough consistency to be treated as findings, not just opinions.

We take the whole person seriously

LD nursing centres the whole person, their history, their communication style, their family, their network, what they say and what they cannot say. This is not just a value; it is a clinical approach that produces better outcomes and fewer crises. It is also the approach that the NHS says it wants from all nursing, but that LD nursing actually delivers.

> *"We look at the person holistically and take into account history, experiences, family, carers, what is said and what is not said. We take time and have a full view of the person."*
>
> *— LD Nurse, specialist community service*

We identify what others miss

LD nurses have the training to identify subtle changes in communication, behaviour, and health, changes that the person themselves may not recognise and that other professionals will not notice. This is the clinical mechanism by which diagnostic overshadowing is prevented, and preventable deaths are avoided.

> *"Learning disability nurses have the skills to identify subtle changes in the person's communication, behaviour or health and advocate for that person. The person themselves may not recognise the change and other professionals certainly wouldn't."*
>
> *— Mental Capacity Nurse Specialist*

We coordinate what the system cannot

People with learning disabilities are often under many services simultaneously. LD nurses coordinate that complexity, streamlining appointments, facilitating multiple investigations under one admission, and translating between services. The system produces this complexity; LD nursing absorbs it on behalf of the people who cannot.

What We Do for Teams and Systems

The impact of LD nursing on organisations and teams is one of the most compelling arguments for investment, and one of the least visible. The evidence from Activity 2 is clear: one skilled LD nurse changes how an entire ward or team behaves. That multiplier effect is a significant return on investment.

> *"Staff are feeling more confident in delivering high quality care to people with learning disabilities without the need for the learning disability liaison nurse to "hand hold" through every contact."*
>
> *— Mental Capacity Nurse Specialist, Acute Hospital*

> *“LD nurses can provide leadership from a practice and organisational perspective and lead innovation with people with lived experiences.”*

— Organisation and Practice Leader

What Would Be Lost: The Honest Answer

This is the most important section of the report, and the one that needs to be heard most clearly by those who make decisions about the workforce. Participants were asked what would happen without LD nursing. Their answers, from across every setting, were unambiguous.

> *“The Mental Capacity Act would not be followed. Likelihood of over-medication to manage behaviours of distress in hospital. Earlier death rates.”*

— Attendee, Activity 2

> *“People lost in the system without a voice, and a workforce with knowledge gaps.”*

— Attendee, Activity 2

> *“Catastrophic.”*

— Organisation and Practice Leader, 20+ years

Those words, "avoidable deaths", "over-medication", "neglect", "catastrophic", came from people who have been doing this work for between one and forty years, across acute hospitals, community teams, forensic services, CAMHS, and social care. This is not hyperbole. It is professional judgement, expressed by people who have seen what happens when the support is absent.

The Strongest Message for Decision-Makers

Participants were asked for one key message for leaders. The following three were chosen for this report because they make the structural argument most clearly, and because they are the arguments most likely to move people who were not in that room.

> *“Invest in learning disability nursing leadership, involve these professionals in strategic decisions, and you will build more equitable, effective, and humane health and social care systems.”*

— MHLD Nurse, 5–10 years

> *“LD nursing is historically and consistently undervalued. Because there is no "recovery" from LD doesn't mean that specialist LD nursing is less valuable to the individual's quality of life and health outcomes. To be a LD nurse is to be a truly holistic nurse.”*

— Specialist LD Service Nurse, 20+ years

> *“I work with LD lived experience leaders. It is clear without the support of LD nurses they would not be living quality lives. Investment in time early on minimises risk for the future.”*

— Lived Experience Team Leader

Chapter 3

What We Do Next

Activity 3: Our Collective Actions for the Next 6–12 Months

Activity 3 asked: How do we build a collective voice? Who do we need to influence? And what one thing should we commit to together? The responses were practical, grounded, and consistent. This chapter sets out the proposed collective actions, explicitly linked to what participants said and invites the group to take them forward.

You Said This. So, We Are Proposing This.

Each of the three proposed collective actions below is drawn directly from the themes that emerged in Activity 3. The link is made explicit here because it matters: these are not actions that have been decided for you. They are actions that came from you.

You told us: we need regular spaces like this one

> *"Arrange a follow-up meeting, perhaps virtually. Map roles being undertaken by nurses."*
>
> *— Attendee, Activity 3*

> *"Regular creative spaces like this. Our collective voice ought to influence HEIs and providers."*
>
> *— Attendee, Activity 3*

> **COLLECTIVE ACTION 1 — FORMALISE THE NETWORK:** Establish a Kent and Medway LD Nursing Network meeting at least quarterly, in person or virtually, with lived experience representation and a shared agenda linked to local workforce planning and the ICS strategy. Connect it to the Kent, Surrey and Sussex Learning Disability Community of Practice. Resource it properly: even a small amount of coordination time makes the difference between a network that meets once and one that lasts.

You told us: LD nursing is invisible to young people and the next generation

> *"Visit universities and make it easier for students to switch courses. Visit schools or have more open days."*
>
> *— Attendee, Activity 3*

> *"Engage lived experience leaders to support in presenting to schools and colleges with LD nurses."*
>
> *— Attendee, Activity 3*

> *"We and our clients are still hidden. Going into schools pre-options. Job fairs. Universities pre-application."*
>
> *— Attendee, Activity 3*

> **COLLECTIVE ACTION 2 — TAKE THE CONVERSATION INTO SCHOOLS:** Develop and launch a coordinated outreach programme into at least five schools or colleges across Kent and Medway within twelve months, co-delivered by LD nurses and lived experience partners. Aim for Key Stage 3 and 4 audiences. Use the stories from this report and the voices from this day as the content.

You told us: the qualitative case is strong, but we need better evidence

> *"Consider what data we can collect and share to evidence the positive impact of learning disability nursing."*
>
> *— Attendee, Activity 3*

> *"Mapping where LD staffing is better and whether that correlates with better outcomes."*

— Attendee, Activity 3

> **COLLECTIVE ACTION 3 — BUILD THE EVIDENCE BASE:** Agree on a small working group to develop a data and outcome framework that captures the preventative impact of LD nursing — for use in business cases, commissioning conversations, and workforce arguments. This does not need to be a large project. It needs to be a consistent one.

Who We Need to Reach

Participants identified the following as the most important people and groups to influence. This is not an exhaustive list; it is the list that came from the room.

- Chief Nurses and senior nursing leadership across all Trusts and the ICB
- Primary Care Networks and GP practices (every PCN to have LD nurse access for annual health checks)
- Higher education institutions — to protect and promote the RNLD training pathway
- Matrons and service managers in mainstream services
- Commissioning and quality teams at the ICB
- People with lived experience, families, and carers — as partners, not just recipients
- Local media and NHS communications teams
- Schools, colleges, and careers services
- The LeDeR programme — to ensure LD nursing's role in preventing premature deaths is documented

What Would Help Us Act

Participants were clear about what would make a difference. The asks are practical.

- **Regular network events and knowledge-sharing sessions** — structured and protected, not squeezed into gaps between caseloads.
- **Dedicated time for advocacy and profile-raising** — this work cannot happen on top of a full clinical load without something giving.
- **Data and outcome tools** — that capture what we prevent, not just what we do.
- **Apprenticeship and secondment routes into LD nursing** — to bring new people in through multiple pathways.
- **Access to briefings and system communications** — being kept in the loop about changes that affect LD services.

Our Collective Vision: The Strategy Sentences

Participants were asked to offer one sentence they would like to see in a future strategy or action plan. These are the sentences that came back. They read like a manifesto, so they are presented as one.

- **Collective research and development opportunities in learning disability nursing in Kent and Medway.**
- **A commitment from all agencies to ensure health equality for people with LD.**
- **People with LD face more health issues and significant barriers to accessing care — LD nurses reduce this inequality in both physical and mental health.**

- **Learning disability nurses will be represented at every level of leadership and decision-making.**

- **All nurses should have a good level of knowledge and education and be able to work with and signpost individuals with a learning disability and/or autism.**

- **Implementation of research and evidence-based practice.**

- **A clear plan for what the future of the LD workforce will be.**

- **An agreed commitment to identify the value and roles of learning disability nursing in collaboration with people with LD.**

- **Keep LD nursing registration.**

What Happens Now

On 17 February 2026, a room full of people who care deeply about learning disability nursing came together and said something important — clearly, collectively, and on the record. This report is one output of that day.

The more important output is what happens next.

An Invitation

The next steps below are offered as an invitation, not a checklist. Do what you can, from where you are, with what you have.

If you were in the room, you might consider:

- Sharing this report with one colleague or leader who wasn't there.
- Identifying one thing you can do in your own setting, a drop-in, a school visit, a conversation with your matron or service manager.
- Signing up to the Kent and Medway LD Nursing Network when it launches.

If you weren't there, you might consider:

- Reading the report and adding your voice, a supplementary survey can be distributed to those who couldn't attend.
- Connecting with someone who attended and finding out about the next event.

> *"The passion of learning disability nurses to ensure that the voices of the people they support are heard is always inspiring."*
>
> *— Case Manager, Kent, Surrey and Sussex Adult Secure Services*

This report was produced from anonymised participant data gathered at the Kent and Medway RNLD CPD Event, 17 February 2026. All quotations are used with participant consent. The full consolidated response dataset is available as a supporting document upon request.